Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Refer to: N6

Provider Number: 23-0105

April 12, 2004
(via Certified Mail)

Thomas Mroczkowski
Chief Executive Officer
Northern Michigan Hospital
416 Connable Avenue
Petoskey, MI 49770

Dear Mr. Mroczkowski:

The Centers for Medicare and Medicaid Services has received the report of the March 12, 2004 full Medicare validation survey conducted by the Michigan Department of Community Health, Bureau of Health Systems. Based on our review of the survey findings, we have determined that Northern Michigan Hospital is not in compliance with the following Medicare Conditions of Participation for Hospitals:

Patient Rights	42 CFR 482.13
Physical Environment	42 CFR 482.41
Infection Control	42 CFR 482.42

We have determined that the deficiencies are significant and limit your hospital's capacity to render adequate care and ensure the health and safety of your patients. In addition, a number of deficiencies were found in other Medicare requirements. Enclosed is a complete listing of all deficiencies cited.

When a hospital does not meet the requirements established under Title XVIII of the Act and the additional requirements established by the Secretary of Health and Human Services under the authority contained in Section 1861 of the Social Security Act, Section 1866(b) of the Act authorizes the Secretary to terminate the hospital's participation in the Medicare program.

Based on the determination that your hospital does not comply with the above Conditions and that significant deficiencies exist, we must terminate your Medicare provider agreement. The date on which your agreement terminates is July 11, 2004. The Medicare health insurance program will not make payment for services furnished to patients admitted on or after July 11, 2004. For patients admitted prior to July 11, 2004, payment may continue to be made for up to 30 days of services furnished on or after July 11, 2004.

You may, of course, take steps to come into compliance with the Medicare Conditions of Participation. If you believe compliance has been achieved, please notify this office immediately. If you believe your hospital will be able to come into compliance, you should

submit a plan of correction to our office and the Michigan Department of Community Health, Bureau of Health Systems within ten (10) days of receipt of this notice. We will review your plan and advise you of its acceptability.

Please note that your plan of correction must be specific, stating exactly how the deficiency was or will be corrected, the expected completion dates, how your plan/action will prevent recurrence and who is responsible for correction and ongoing monitoring. A response to each deficiency on the enclosed CMS-2567 is required and the right hand column of the CMS-2567 must be used to document your plan for corrective action. The CMS-2567 may not be altered in any form. The plan must be signed and dated at the bottom of the first page of the CMS-2567 by the authorized official at your hospital. Additional documentation may be attached to the CMS-2567, when necessary. If a deficiency has been corrected since the survey, this should be indicated on the form along with the date of correction.

If we accept your allegation of compliance, the Michigan Department of Community Health, Bureau of Health Systems will conduct a revisit. If you cannot achieve compliance by the termination date, you may reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act.

If you believe that the decision to terminate your participation in the Medicare program is not correct, you may request a hearing before an Administrative Law Judge of the Department of Health and Human Services, Departmental Appeals Board. If you desire a hearing, you must request it no later than 60 days from the date you receive this notice. The request for a hearing should state why the decision is considered incorrect and should be accompanied by any evidence which you decide to bring to the attention of the hearing examiner. Evidence may also be presented at the hearing, where you may be represented by counsel. The request for a hearing should be sent to the address given above.

If you have any questions regarding this matter, please contact me in our Chicago Office at (312) 886-5344.

Sincerely,

/s/

Robert P. Daly, Manager
Non-Long Term Care Branch

Enclosure
cc: Michigan Department of Community Health, Bureau of Health Systems
Michigan Department of Community Health
Joint Commission on Accreditation of Healthcare Organizations

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	230105	A. BUILDING _____ B. WING _____	3/12/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MICHIGAN HOSPITAL	416 CONNABLE AVE PETOSKEY, MI 49770

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A 000	INITIAL COMMENTS State Facility Number: 240030 This survey was for the purpose state monitoring. The Department surveyors indicated below have evaluated this facility and have found the stated deficiencies to be those Licensure and/or Federal Certification requirements not in compliance on the dates indicated. The following surveyors conducted this survey: Valerie Belcher, RN, MSA, CPHQ #15196 Hugh Bennett, RN, MSN #02827 Shirley Tuggle, RN, MSN, QMRP #02951 Wandah Hardy, RN, MPA #07110 Jim Scott, PE #02928 For the Department's use only - Statement of Deficiencies. _____ Darryl Horton, Director Date For the Department's use only - Plans of Correction. I have reviewed the facility's Plans of Correction and have made the following determination: ___Acceptable as written ___Acceptable, subject to noted modifications ___Not acceptable	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 _____ Darryl Horton, Director Date	A 000		
A 113	482.24(c)(2)(viii) ELEMENT of STANDARD CONTENT OF RECORD All records must document, as appropriate, final diagnosis with completion of medical records within 30 days following discharge. This ELEMENT is not met as evidenced by: Based on interview with the manager of medical records it was determined that the facility had a total of 577 medical records that were not complete after 30 days following patient discharge.	A 113		
A 185	482.28(a)(3) ELEMENT of STANDARD ORGANIZATION There must be administrative and technical personnel competent in their respective duties. This ELEMENT is not met as evidenced by: Based on observation and staff interview the facility failed to have personnel competent in their dietary duties. Findings include: On tour of the dietary department on 3/9/04 the following was identified: 1. A bottle of water was observed in a refrigerator in the dietary department where food items for patient use was located. When queried the manager identified that the bottle of water belonged to one of the employees in the department.	A 185		

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A 185	Continued From page 2 2. Multiple scoops were located in the bins of staple products, flour, rice. 3. Three staff personnel on the hot tray line were observed wearing hair nets improperly. Not all hair was covered by a hairnet and hair nets were not placed properly on the forehead as outlined by facility policy and the 1999 Food Code. 4. Freezer logs temperatures were noted to be documented inconsistently. Interview with the manager indicated that temperatures were to be recorded twice daily. Review of forms revealed that temperatures were being recorded only once daily.	A 185		
A 226	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based upon on-site observation, document review and staff interview during the life safety portion of a state monitoring survey conducted on March 9-12, 2004, as a result of a previous complaint investigation, the surveyors find that the facility failed to provide and maintain a safe environment for patients and staff. This is evidenced by the severity, variety and number of Life Safety Code deficiencies that were found. See also A-230.	A 226		

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A 227	Continued From page 3	A 227		
A 227	482.41(a) BUILDINGS The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: The potable water system is not adequately protected from the possibility of contamination. Steris machines for scope cleaning and disinfection are located in the sub-sterile rooms between Operating Rooms 7 & 8 and between Operating Rooms 5 & 6. Approved backflow prevention devices have not been installed on the plumbing connections to these Steris machines. An atmospheric type vacuum breaker was provided on the water supply to a film processor in the radiology darkroom serving the mammography area. This is not an approved backflow prevention device for this application. Approved backflow prevention devices could not be located on the new scope cleaning equipment in the Endoscopy Suite.	A 227		
A 230	482.41(b) LIFE SAFETY FROM FIRE Life safety from fire This STANDARD is not met as evidenced by: Based upon on-site observation, document review and staff interview during the Life Safety portion of a state monitoring survey conducted on March 9-12, 2004, the surveyors find that the facility does not comply with the applicable provisions of the 2000 Edition of the Life Safety Code. See the Life Safety Code deficiencies identified with K-tags on the CMS-2567 dated March 11,	A 230		

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A 230	Continued From page 4 2004.	A 230		
A 240	482.41(c)(2) ELEMENT of STANDARD FACILITIES Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This ELEMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure an acceptable level of safety and quality of supplies and equipment. Findings include: During tour of the pharmacy department on 3/10/04 at approximately 10:30 a.m., a coffee maker was noted to be in the pharmacy dispensing area. When asked about this, the pharmacy manager stated that pharmacists like their coffee but affirmed that this was not the best practice. Under sink storage was observed in the ambulatory surgical area. The storage under the sink contained a sharps container, cleaning supplies and paper products. Also, under the sink storage in the surgical suite soiled utility room was observed cleaning supplies and surgical equipment.	A 240		
A 257	482.51(b)(1) ELEMENT of STANDARD DELIVERY OF SERVICE There must be a complete history and physical work-up in the chart of every patient prior to surgery, except in emergencies. If this has been dictated, but not yet recorded in the patient's	A 257		

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A 257	Continued From page 5 chart, there must be a statement to that effect and an admission note in the chart by the practitioner who admitted the patient. This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to insure that a properly executed history and physical document was in the chart of a patient prior to surgery. This was noted for 1 (#52) of 4 sample surgical charts. Findings include. A tour of the surgical department was conducted on 3/11/04. During review of pre-surgical records it was noted that for patient #52 a history and physical form was on the chart. This H&P was not dated and or timed yet it had been signed by the surgeon. Interview with the staff revealed that the form should have been dated and timed prior to the surgeon's signature.	A 257		
A 258	482.51(b)(2) ELEMENT of STANDARD DELIVERY OF SERVICE A properly executed informed consent form for the operation must be in the patient's chart before surgery, except in emergencies. This ELEMENT is not met as evidenced by: Based on interview and record review the facility failed to insure that a properly executed informed consent forms was on the patient's chart before surgery. This was noted for 2 of 4 sample patients (#44, #45). Findings include: On 3/11/04 during surgical tour and review of #44 and #45's surgical records it was noted that the consents for the surgical procedure had dates which had been crossed out and a different date written in. No documentation related to the author	A 258		

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A 258	Continued From page 6 of the changes was noted on the forms. Therefore, the procedure consent form was not properly dated as specified by facility policy.	A 258		
A 273	482.52(b)(3) ELEMENT of STANDARD DELIVERY OF SERVICES The policies must ensure that each inpatient receives a postanesthesia followup report by the individual who administers the anesthesia that is written within 48 hours after surgery. This ELEMENT is not met as evidenced by: Based on interview and record review the facility (medical staff) failed to document a required follow-up visit. This was noted for 1 of 2 (#16) sample surgical patients. Findings include: On tour of the Medical-Surgical Unit on 3/9/04 and review of medical records it was noted that patient #16 did not have a post-anesthesia evaluation documented in the record in accordance with the By-Laws of the facility and federal regulations which required a post-anesthesia evaluation note to be documented in the medical record.	A 273		
A 750	482.13 PATIENTS' RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on staff interview and record review, it was determined that the facility failed to protect and promote each patient's rights during the grievance process as required.	A 750		

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A 750	Continued From page 7 See citations A752, A756, & A757 dated 3/12/04.	A 750		
A 752	482.13(a)(2) NOTICE OF RIGHTS The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. This STANDARD is not met as evidenced by: Based on staff interview and record review, it was determined that the facility failed to consistently implement a process for the prompt resolution of patient grievances in 2 of 6 cases reviewed (Pt. #48 & 49). Findings include: Record review and interview with the Patient Relations Representative, her supervisor and the Risk Manager on 3/10/04, revealed that the facility had failed to implement a consistent process for the prompt resolution of patient grievances filed in 2 of 6 cases reviewed (#48, 49). There was no documented evidence on file of any investigation or staff inquiry regarding the filed grievances. The two cases were identified as closed on 9/22/03 & 12/17/03 respectively, without any findings or determinations as required. When queried the Patient Relations Representative was unable to explain the practice.	A 752		
A 756	482.13(a)(2)(ii) NOTICE OF RIGHTS The grievance process must specify time frames for review of the grievance and the provision of a response.	A 756		

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A 756	Continued From page 8 This STANDARD is not met as evidenced by: Based on staff interview and record review, it was determined that the facility's grievance process failed to show evidence of specific time frames for review of the grievance and the provisions of a response as required in 6 of 6 cases reviewed (Pt. #34, 46, 47, 48, 49, 50). Findings include: In interview the Patient Relations Representative acknowledged on 3/10 & 3/11/04, that in 6 of 6 cases reviewed, (Pt. #34, 46, 47, 48, 49, 50) none of them were provided any written correspondence identifying acknowledgement of the grievance filed/received and the time frames for an expected review with the provisions of a future response as required.	A 756		
A 757	482.13(a)(2)(iii) NOTICE OF RIGHTS In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Based on staff interview and record review, it ws determined that the facility failed to provide 4 of 6 patients reviewed (#46, 47, 48, 49) with filed grievances with written notice of its decisions that contained the steps taken on behalf of the patients to investigate the grievance, the results and the date of completion as required. Findings include:	A 757		

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A 757	Continued From page 9 Record review and interview with the Patient Relations Representative revealed that 4 of 6 patients (#46, 47, 48, 49) with closed grievance cases, never received any written notice of the facility's decisions, findings or determinations with completion dates related to their grievance filed as required.	A 757		